MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2007

UNITED HEALTHCARE OF COLORADO, INC.

6465 South Greenwood Plaza Blvd.
Centennial, CO 80111

NAIC Company Code 95090
NAIC Group Code 707

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

CERTIFICATE OF COPY

I, **Marcy Morrison**, Commissioner of Insurance of the State of Colorado, do hereby certify that the attached is a true and correct copy of the Market Conduct Examination Report as of December 31, 2007 for **United HealthCare of Colorado, Inc.** now on file as a record of this office.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal of office at the City and County of Denver on this 28th day of August 2009.

Marcy Morrison
Commissioner of Insurance

UNITED HEALTHCARE OF COLORADO, INC.
6465 South Greenwood Plaza Blvd.
Centennial, CO 80111

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2007

Examination Performed by:

Regulatory Consultants, Inc.

Nestor J. Romero, CPA, CFE, CIE
Examiner-In-Charge

Jimmy Potts, FLMI, CLU, AIRC, CIE

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS, MCM

Lynn L. Zukus, AIE, FLMI

April 30, 2009

The Honorable Marcy Morrison
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Morrison:

This limited market conduct examination of United HealthCare of Colorado, Inc. (the Company), was conducted pursuant to §§ 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-416, C.R.S., which authorize the Insurance Commissioner to examine health maintenance organizations (HMOs). We examined the Company's records at its principal executive office located at 6465 S. Greenwood Plaza Blvd., Suite 300, Englewood, Colorado, 80111. The market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The following market conduct examiners respectfully submit the results of the examination.

Nestor J. Romero, CPA, CFE, CIE

Jimmy Potts, FLMI, CLU, AIRC, CIE

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP, ACS, MCM

Lynn L. Zukus, AIE, FLMI

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COMPANY PROFILE

The following profile is based on information provided by the Company:

United HealthCare of Colorado, Inc. (UHcCO) has its principal executive office at 6465 South Greenwood Plaza Boulevard, Suite 300, Centennial, CO, 80111-4722. UHcCO was incorporated in Colorado on February 24, 1986, under the name MetLife HealthCare Network of Colorado, Inc. and commenced operations as a health maintenance organization in Colorado on March 20, 1986. UHcCO was a wholly owned subsidiary of MetLife HealthCare Management Corporation ("MHMC"), a Delaware corporation and wholly owned subsidiary of Metropolitan Life Insurance Company. On July 11, 1995, as a result of the formation of The MetraHealth Companies, Inc., by Metropolitan Life Insurance Company and The Travelers, Inc., MetLife HealthCare Network of Colorado, Inc. changed its name to The MetraHealth Care Plan of Colorado, Inc. On June 7, 1995, MHMC changed its name to MetraHealth Care Management Corporation. On November 1, 1999, the Colorado Division of Insurance granted permission for MHMC to transfer its ownership of UHcCO to UnitedHealthcare, Inc., a Delaware corporation and wholly owned indirect subsidiary of United HealthCare Corporation ("United"), a Minnesota corporation incorporated in January 1977. On March 7, 2000, United changed its name to UnitedHealth Group Incorporated. Effective September 30, 2000, UHcCO became a wholly owned direct subsidiary of UnitedHealthcare, Inc. ("UHc"), a Delaware corporation and wholly owned indirect subsidiary of United.

The Company is licensed to operate as a health maintenance organization in Colorado.

United HealthCare, Inc. does not offer products on the individual level.

Premium and Market Share as of December 31, 2007:	4,332
Total Written Premium:	$20,514,000*
Small Group Written Premium:	$ 7,678,586**

Market Share	(as a percentage of Colorado Total Accident and Health):	0.23%
	(as a percentage of Colorado Total Small Group):	0.60%

* As shown in the 2007 Edition of the Colorado Insurance Industry Statistical Report
** As provided by the company to the Division in the Small Group Activity Report

PURPOSE AND SCOPE

Independent contract examiners for the Colorado Division of Insurance (Division), in accordance with Colorado insurance laws, §§ 10-1-201, 10-1-203, 10-1-204, 10-1-205(8), and 10-16-416, C.R.S., which empower the Commissioner to examine any entity engaged in the insurance business, reviewed certain business practices of United HealthCare of Colorado, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Division.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance laws related to HMO's. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record.

Examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained and/or supplied by the Company. The limited market conduct examination covered the period from January 1, 2007, through December 31, 2007.

The examination included review of the following:

Company Operations and Management
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws as they pertained to HMO's. Examination findings may result in administrative action by the Division. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance company product.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of seven percent (7%) for claims, or ten percent (10%) for other samples, was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g., timeliness of claims payment), and if one or more of the samples yielded an exception rate higher than the minimum tolerance level, the results of any other samples with exception percentages less than the minimum tolerance were also included.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws. For this examination, special emphasis was given to the statutes and regulations as shown in Exhibit 1.

Exhibit 1

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans – rules – benefit design advisory committee – repeal.
Section 10-16-105.2, C.R.S.	Small employer health insurance availability program.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – loss ration guarantees – disclosures on treatment of intractable pain
Section 10-16-107.2, C.R.S.	Filing of health policies
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.5, C.R.S.	Fair marketing standards.
Section 10-16-109, C.R.S.	Rules and regulations.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-113.7, C.R.S.	Reporting the denial of benefits to the division.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modifications of health benefit plans.
Section 10-16-214, C.R.S.	Group sickness and accident insurance.
Section 10-16-401, C.R.S.	Establishment of health maintenance organizations.
Section 10-16-403, C.R.S.	Prohibited practices.
Section 10-16-407, C.R.S.	Information to enrollees.
Section 10-16-413, C.R.S.	Prohibited practices
Section 10-16-416, C.R.S.	Examination
Section 10-16-421, C.R.S.	Statutory construction and relationship to other laws.
Section 10-16-423, C.R.S.	Confidentiality of health information.
Section 10-16-427, C.R.S.	Contractual relations.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Insurance Regulation 1-1-4	Maintenance of Offices in this State
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts
Insurance Regulation 1-1-7	Market Conduct Record Retention

Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-5	Hospital Definition
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-11	Rate Filing And Annual Report Submissions Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits
Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Insurance Regulation 4-2-20	Concerning the Colorado Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Conversion Coverage
Insurance Regulation 4-7-1	Health Maintenance Organizations
Insurance Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous limited market conduct examination which covered the period January 1, 2002 through December 31, 2002, and which was completed October 9, 2003,.

Cancellations/Non-Renewals/Declinations

For the period January 1, 2007 through December 31, 2007 the data provided by the Company indicated a population of eighty-one (81) terminated files. Per the underwriting section of the Company, small business does not decline, rescind or non-renew any cases. The examiners reviewed a randomly selected sample of forty (40) small group cancelled files for compliance with statutory requirements and contractual obligations:

Claims

In order to determine the Company's compliance with Colorado's prompt payment of claims law as well as the proper and accurate payment of claims, the examiners reviewed the following random samples:

- One hundred nine paid claim files for accuracy of processing
- One hundred nine denied claim files for accuracy of processing
- Seventy-six (76) electronically received paid claim files processed in greater than thirty (30) days and less than ninety (90) days
- One hundred seven non-electronically received paid claims files processed in greater than (45) days and less than ninety (90) days
- One hundred nine paid claim files processed in greater than ninety (9)0 days
- One hundred nine denied claim files reviewed to determine accuracy of quarterly reporting required by the Division
- Thirty-three (33) claims where data indicated that services were provided on the same date of service on both an in-network and out-of-network basis to determine if out-of-network claims were being processed in accordance with law when services were performed in an in-network facility.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures.

The Company has contracted with ACN Group, Inc., for utilization review of physical health services. Physical health services include chiropractic as well as physical and occupational therapy services provided in outpatient, non-hospital based settings.

United Healthcare Services, Inc. performs the utilization review functions for the Colorado members for certain non-physical health services. Medical and dental (accidental) services on the required notification list receive pre-service review by staff within this entity.

United Behavioral Health (UBH) is a business unit within UnitedHealth Group that performs the utilization review functions for claims related to mental health or behavioral issues.

The Central Escalation Unit (CEU) manages commercial clinical and administrative appeals and works with its clinical review partners – Medical Claim Review (MCR), Care Coordination (CCR) and Medco Health Solutions, Inc., United Healthcare's pharmacy benefits services administrator – to facilitate all required clinical reviews.

The examiners selected the following random samples for review of the Company's overall utilization review handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons in order to determine compliance with Colorado insurance law.

Approved Standard Utilization Review Determinations

Thirteen (13) Prospective -Central Escalation Unit (CEU)

Thirty-two (32) Retrospective-Central Escalation Unit (CEU)

Four (4) United Health Care (UHC)

Sixty-four (64) ACN Group, Inc.

Denied Standard Utilization Review Determinations

Six (6) Prospective-Central Escalation Unit (CEU)

Twenty-five (25) Retrospective-Central Escalation Unit (CEU)

Seventeen (17) ACN Group, Inc.

Appeals

Twenty-nine (29) First Level - Central Escalation Unit (CEU)

One (1) Second Level - Central Escalation Unit (CEU)

EXAMINATION REPORT SUMMARY

The examination resulted in a total of nine (9) findings in which the Company did not appear to be in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Operations and Management: There were no exceptions meeting our materiality threshold identified by the examiners in their review of the Company's Operations and Management:

Cancellations/Non-Renewals/Declinations: There were two (2) areas of concern identified during the review of the small group cancellation files.

Issue H1: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan. ***(This was prior issue H4 in the findings of the 2002 final examination report.)***

Issue H2: Failure to reflect the definition of a "significant break in coverage" in certificates of creditable coverage.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company:

Issue J1: Failure, in some instances, to process claims correctly.

Issue J2: Failure, in some cases, to pay late payment interest and/or penalties.

Issue J3: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Issue J4: Failure to correctly process claims for out-of-network services/treatment associated with services/treatment rendered at an in-network facility.

Utilization Review: The examiners identified three (3) areas of concern in their review of the Company's Utilization Review procedures:

Issue K1: Failure, in some instances, to have a physician evaluate first level reviews, to take into consideration the treating provider's comments in conducting a first level review that resulted in a denial, and to include all required information in denial notification letters for first level reviews.

Issue K2: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.

Issue K3: Failure, in some instances, to provide notification of determinations within the required timeframes. (This ***was prior issue K1 in the findings of the 2002 final examination report.)***

Results of previous market conduct examinations are available on the Division's website at www.dora.state.co.us/insurance or by contacting the Division.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

UNITED HEALTHCARE OF COLORADO, INC.

CANCELLATIONS/NON-RENEWALS/DECLINATIONS

Issue H1: Failure, in some instances, to offer to each member of terminating small groups a choice of the Basic or Standard Health Benefit Plan. ***(This was prior issue H4 in the findings of the 2002 final examination report.)***

Section 10-16-108(4), C.R.S., Conversion and continuation privileges, states in part:

(4) Special provisions for small group health benefit plans

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.

(c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:

(I) If an individual is eligible for continuation coverage or conversion coverage pursuant to section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of this paragraph (c) shall not apply to such an individual; and

(II) If an individual lost nexus to group coverage for fraud or abuse in procuring or utilizing coverage, then the provisions of this paragraph (c) shall not apply to such an individual.

SMALL GROUP TERMINATED FILE SAMPLE

Population	Sample Size	Number of Exceptions	Percentage of sample
81	40	21	53%

The examiners reviewed a sample of forty (40) files that were randomly selected from a population of eighty-one (81) files identified as small group cancellations during the exam period of January 1, 2007 through December 31, 2007. It appears that the Company is not in compliance with Colorado insurance law in that upon termination of the group policy for the reasons indicated below, in twenty-one (21) cases, the Company failed to offer to each member of the terminating small group a choice of the Basic or Standard Health Benefit Plan as required by law.

NON-PAYMENT

In two (2) cases there was an "Account Termination Notice" located in the files in which non-payment was indicated as the reason for termination, and this notice was sent only to the terminating employer, and stated:

> Please advise your employees immediately that their coverage has been cancelled. If you are eligible for reinstatement, please contact 888-842-4571 within 30 days of the date of this letter. Note: Enrollees living in the state of Colorado may be eligible for Colorado

Basic or Standard Health Benefit Plans. Please call the Conversion Customer Service Unit at (866) 747-1019.

NO REASON GIVEN

In nineteen (19) cases, the employer exercised their right to terminate the policy with no indication of replacement coverage. There was no documentation in the files indicating that the Company made an offer of the Basic and Standard Health Benefit Plans as required, nor that they made an attempt to determine if replacement coverage had been obtained.

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-108(4) C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that each member of a terminating small group, for reasons other than replacement of coverage or fraud and abuse in procuring and utilizing coverage, is offered a choice of the Basic or Standard Health Benefit Plan in compliance with Colorado insurance law.

In the Market Conduct examination for the period January 1, 2002 through December 31, 2002 the Company was cited for failure to offer Basic and Standard Plan conversion coverage to terminating small employer groups. The violation resulted in Recommendation #24; that the Company revise its procedures to ensure that a choice of the Basic or Standard Health Benefit Plans is offered to each member of the group whose policy is terminating, as required by Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of § 10-1-205, C.R.S.

Issue H2: Failure to reflect the definition of a "significant break in coverage" in certificates of creditable coverage.

Colorado Insurance Regulation 4-2-18, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

Section 2. Purpose and Background

> The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage for purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 2004 amendments to this regulation is to make clarifications and allowances to ensure Colorado consumers receive correct certificates of creditable coverage in a timely manner.

Section 3. Applicability and Scope

> This amended regulation shall apply to all certificates of creditable coverage issued on or after October 1, 2004.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.* [Emphasis added.]

B. Colorado law concerning creditable coverage.

4. Certifying creditable coverage

> Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance *must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphasis added.]

The Company provided Certificates of Creditable Coverage (COCC) for an initially designated eight (8) small group terminated sample files. None of these COCC forms appeared to reflect the definition of "significant break in coverage" required by Colorado insurance law. The Company responded to an examiner's inquiry that its COCC forms are universal and the same for all groups and members that have terminated coverage with the Company. Given the Company's response, no additional Certificates were reviewed.

SMALL GROUP CERTIFICATES OF CREDITABLE COVERAGE SAMPLE

Population	Sample	Number of Exceptions	Percentage of sample
81	8	8	100%

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all Certificates of Creditable Coverage reflect the definition of a "Significant break in coverage" in compliance with Colorado insurance law.

CLAIMS

Issue J1: Failure, in some instances, to process claims correctly.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

(f) Unfair discrimination:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, *or in the benefits payable thereunder*, or in any of the terms or conditions of such contract, or in any other manner whatever; [Emphasis added.]

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims under insurance policies;

(IV) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information

necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

Section 10-16-704 C.R.S., Network adequacy - rules - legislative declaration - repeal, states in part:

(3)(b) *When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit.* [Emphasis added] Covered services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider.

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states in part:

Section 6. Additional Information

A. A claim with all required fields completed is not considered "clean" if additional information is needed in order to adjudicate the claim. Carriers may request additional information *only if the carrier's claim liability cannot be determined with the existing information on the claim form* and the information requested is likely to allow a determination of liability to be made. [Emphasis added.] When additional information is required, the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form. *If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim.* [Emphasis added.] The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request.

PAID CLAIMS RECEIVED IN 2007

Population	Sample	Number of Exceptions	Percentage of sample
10,714	109	9	8%

The Company provided a population of 10,714 paid claims received in 2007. A sample of 109 claims was randomly selected for review by the examiners. From a review of this sample it appears that nine (9) claims were processed incorrectly.

- Seven (7) claims were incorrectly denied due to lack of notification to the Company.
- One (1) claim was paid incorrectly due to application of an incorrect provider fee schedule.
- One (1) claim was paid incorrectly due to application of an incorrect copayment.

DENIED CLAIMS RECEIVED IN 2007

Population	Sample	Number of Exceptions	Percentage of sample
3,427	108	32	30%

The Company provided a population of 3,427 denied claims received in 2007. A sample of 108 claims was randomly selected for review. Of this sample it appears that thirty-two (32) claims were processed incorrectly. The list below indicates the various reasons why the examiners are asserting that the claims were not processed correctly.

- Three (3) claims were incorrectly denied as duplicates.
- Eight (8) claims were incorrectly closed to request accident information without sending notice to the provider.
- Two (2) claims were incorrectly denied to request other insurance information which was not needed.
- Three (3) claims were incorrectly processed as an out-of-network providers.
- One (1) claim had an incorrect provider fee applied.
- Fifteen (15) claims were incorrectly denied for lack of notice to the Company prior to receiving the services or treatment.

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, 10-16-106.5, and 10-16-704, C.R.S., and Colorado Insurance Regulation 4-2-24. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has reviewed and modified its claims processing quality controls to ensure that all claims are investigated properly to determine the proper allocation of benefits as required by Colorado insurance law.

Issue J2: Failure, in some cases, to pay late payment interest and/or penalties.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

PAID ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
224*	76	11	14%

The Company provided a population of 351* electronically received paid claims that exceeded thirty (30) days to process. A sample of seventy-six (76) files was randomly chosen for review. All of these claims appeared to meet the definition of a "clean claim" submission, but were not paid correctly within the time period required by Colorado insurance law. The Company agreed that late payment interest was due on eleven (11) of these claims, but had not been paid. The interest amounts were processed and paid during the examination with documentation of this provided to the examiners.

*The actual number of paid claims processed in excess of thirty (30) days was 351. However, due to an error in the sampling program the examiners only selected paid claims which were processed in more than forty-five (45) days. The examiners are of the opinion that not including paid claims between thirty (30) and forty-five (45) days would not have a material impact on the findings noted in the examination report.

PAID NON-ELECTRONIC CLAIMS PROCESSED OVER 45 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
43	43	12	28%

The Company provided a population of forty-three (43) non-electronically received paid claims that exceeded forty-five (45) days to process. Thirty-three (33) of these claims appeared to meet the definition of a "clean claim" submission, but were not paid correctly within the time period required by Colorado insurance law. The Company agreed that late payment interest was due on twelve (12) of these claims, but had not been paid. The interest amounts were processed and paid during the examination with documentation of this provided to the examiners.

PAID CLAIMS PROCESSED OVER 90 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
523	83	27	33%

The Company provided a population of 523 claims that had not been paid within ninety (90) calendar days from date of receipt. A sample of eighty-three (83) files was randomly selected for review. The Company agreed that late payment penalties were due on twenty-seven (27) of these claims but had not been paid. The penalty amounts were processed and paid during the examination with documentation of this provided to the examiners.

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that late payment penalties are paid in all applicable instances as required by Colorado insurance law. Additionally, a self audit should be performed to ensure that interest and penalties are properly disbursed on all late claims.

Issue J3: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

ELECTRONICALLY RECEIVED PAID CLAIMS PROCESSED OVER 30 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
224*	76	76	100%

The Company provided a population of 351* electronically received paid claims that exceeded thirty (30) days to process. A sample of seventy-six (76) files was randomly chosen for review. All seventy-six (76) claims appeared to meet the definition of a "clean claim" submission, but were not paid correctly within the time period required by Colorado insurance law.

*The actual number of paid claims processed in excess of thirty (30) days was 351. However, due to an error in the sampling program the examiners only selected paid claims which were processed in more than forty-five (45) days.

NON-ELECTRONICALLY RECEIVED PAID CLAIMS PROCESSED OVER 45 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
43	43	33	77%

The Company provided a population of forty-three (43) paid claims received other than electronically that exceeded forty-five (45) days to process. Thirty-three (33) of these claims appeared to meet the definition of a "clean claim" submission, but were not paid correctly within the time period required by Colorado insurance law.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample	Number of Exceptions	Percentage of sample
523	83	81	98%

The Company provided a population of 523 claims that had been received both electronically and by other means (paper) that had not been paid or settled within ninety (90) days. The examiners randomly selected a sample of eighty-three (83) files for review. Eighty-one (81) files did not appear to have been paid correctly within the time period required by Colorado insurance law when either a clean claim submission or when processing was calculated from the date requested additional information was received by the Company. None of these files indicated that any fraud was involved.

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J4: Failure to correctly process claims for out-of-network services/treatment associated with services/treatment rendered at an in-network facility.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

(h) Unfair claim settlement practices: *Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:* [Emphasis added]

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims under insurance policies;

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section *shall be liable for the covered benefit and, in addition, shall pay to*

> *the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim,* accruing from the date payment was due pursuant to subsection (4) of this section.
>
> (b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim *shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim.* Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. [Emphases added.]

Section 10-16-704, C.R.S., Network adequacy – rules- legislative declaration – repeal, states in part:

> (3)(b) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit. *Covered services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider.* [Emphasis added]

The examiners noted that it appeared that the Company may not be processing out-of-network professional claims when services were provided at an in-network facility in compliance with § 10-16-704(3), C.R.S.

When the examiners requested claims files to verify that the Company was complying with § 10-16-704(3), C.R.S., the Company advised that the Division of Insurance during 2007 had identified a concern wherein a related Company (United Healthcare Insurance Company - UHCIC) was not correctly processing certain claims submitted by out-of-network professional providers for services rendered at an in-network facility. The Division addressed this concern with the UHCIC in correspondence commencing on or about March 30, 2007.

In correspondence specific to UHCIC, the examiners note the following:

UHCIC noted in a letter of June 15, 2007 that "It appears that some claims are being processed incorrectly when the professional claims are received prior to the facility claims, because our claims system is unable to link the out of network professional claim with the in-network facility claim."

UHCIC also stated that it would review the full population of claims "to determine deficient claims and reprocess those claims with restitution to be made to the affected members in accordance with the member's benefit plan."

The Commissioner, in a letter dated July 6, 2007, advised the Company that:

- The Division is "deeply concerned with the harmful effects that UHC's noncompliance with C.R.S. § 10-16-704(3) has on Colorado consumers."

- That the Division is "troubled" that UHC has a systematic inadequacy which prevents it from linking out-of-network professional claims performed in an in-network facility when the out-of-network professional claim is received prior to the in-network facility claim.

- The Company was to provide a detailed summary of the procedures UHC has implemented to ensure that "all out-of-network professional claims are processed correctly when the professional claims are received prior to, but in connection with, an in-network facility claim."

UHCIC responded, in a letter dated July 20, 2007, that it was "implementing the following procedures to ensure compliance with § 10-16-704(3), C.R.S.:

- A systematic claims process will be undertaken to associate an out-of-network professional claim with services rendered at an in-network facility to result in those claims being adjudicated at the in-network benefit level as required by Colorado law.

- United is undertaking an additional self audit for the time period of April 1, 2007 (for claims paid after the self audit was required by DOI) to present to ensure that members claims are being adjudicated in accordance with C.R.S. § 10-16-704(3)."

The examiners conclude that UHCIC was placed on notice of the Division's position relative to processing of claim in accordance with § 10-16-704(3), C.R.S. Therefore, United Healthcare of Colorado was also aware of this position, and appears to be in willful violation of Colorado insurance law as it relates to processing out-of-network professional claims when services are provided at an in-network facility because the Company has been made aware of its non-compliance with Colorado law in its claims processing and has not implemented procedures to ensure compliance.

OON PROVIDER CLAIMS AT INN FACILITIES

Population	Sample	Number of Exceptions	Percentage of sample
33	33	8	24%

The examiners identified a total population of thirty-three (33) claims where the data provided by the Company would appear to indicate that there were out-of-network (OON) claims processed in conjunction with in-network (INN) facility claims. After reviewing these thirty-three (33) claims, it was determined that there were eight (8) claims which were submitted by OON providers for services provided at INN facilities. The balance of the claims were either submitted by INN providers or were duplicates of the OON or INN claims. None of these eight (8) claims were correctly paid at the in-network benefit level.

The examiners consider these eight (8) claims as being violations as the payment date or adjustment date occurred after the Company was put on notice by the Commissioner's letter dated July 6, 2007 of the requirement to pay claims of this type at the in-network benefit level.

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of §§ 10-3-1104, & 10-16-106.5 and 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has revised its claim payment procedures to ensure that all out-of-network professional claims are processed correctly when the claims are received prior to, but in connection with, an in-network facility claim in compliance with Colorado insurance law. Additionally, a self audit should be performed to ensure that all claims were paid at the proper benefit level, and that interest and penalties are properly disbursed where appropriate.

UTILIZATION REVIEW

Issue K1: Failure, in some instances, to have a physician evaluate first level reviews, to take into consideration the treating provider's comments in conducting a first level review that resulted in a denial, and to include all required information in denial notification letters for first level reviews. (*This was a partial repeat of prior issue K4 in the findings of the 2002 final examination report.)*

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 10 First Level Review

E. Conduct of first level reviews.

1. *First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer*. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

2. *In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination.* If the appeal is pursuant to Section 10-16-113(1)(c), C.R.S., regarding the applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

G. Notification requirements

1. A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in Paragraph 2. or 3.

I. The decision issued pursuant to Subsection G. shall set forth in a manner calculated to be understood by the covered person:

1. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers".);

2. A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;

3. The reviewers' decision in clear terms; and

4. *A reference to the evidence or documentation used as the basis for the decision.* [Emphases added.]

The examiners reviewed the entire population of twenty-nine (29) first level review files provided by the Company. In three (3) of these files a determination was made to uphold the denial of benefits and it does not appear that a physician evaluated the appeal as required. In addition, it does not appear that the treating provider's comments were taken into consideration of the appeal as required. All three (3) cases involved prescription drug denials in which treating provider's comments were not considered before a determination to deny the review was made. As a result, none of the three (3) denial letters included:

- The name, title and qualifying credentials of the physician evaluating the appeal;
- A statement of the reviewers' understanding of the covered person's request for a review of an adverse determination;
- The reviewers' decision in clear terms; and
- A reference to the evidence or documentation used as the basis for the decision.

CENTRAL ESCALATION UNIT (CEU) FIRST LEVEL REVIEWS

Population	Sample Size	Number of Exceptions	Percentage of sample
29	29	3	10%

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all first level reviews are evaluated by a physician who shall consult with an appropriate clinical peer or peers unless the reviewing physician is a clinical peer, as required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 2002 through December 31, 2002, the Company was cited for failure to include all required information in denial notification letters for First Level Appeals. The violation resulted in Recommendation #32; that the Company revise its procedures to ensure that First Level Appeal determination letters contain all the information required by Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue K2: Failure, in some instances, to have written denials of requests for benefits as not medically necessary, appropriate, effective, or efficient signed by a licensed physician.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states in part:

> 4. All written denials of requests for covered benefits on the ground that such benefits are *not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado.* … [Emphasis added.]

UHC RETROSPECTIVE DENIAL DETERMINATIONS

Population	Sample	Number of Exceptions	Percentage of sample
25	25	2	8%

The examiners reviewed the entire population of twenty-five (25) United HealthCare (UHC) retrospective denial determination files provided by the Company. In two (2) of these files an adverse determination was made for which the Company provided only an Explanation of Benefits (EOB). These EOB's do not meet the requirement of Colorado insurance law with respect to being signed by a licensed physician.

CEU DENIAL DETERMINATIONS

Population	Sample	Number of Exceptions	Percentage of sample
6	6	1	17%

The examiners reviewed the entire population of six (6) CEU denial determination files provided by the Company. In one (1) of these files an adverse determination was made and the notification letter was not signed by a licensed physician.

ACN GROUP DENIED STANDARD UTILIZATION REVIEW DECISIONS

Population	Sample	Number of Issues	Percentage of sample
14	14	14	100%

The Company has contracted with the ACN Group, Inc., to perform clinical review services. The examiners reviewed the entire population of seventeen (17) ACN denied standard utilization review decisions. Three (3) decisions were determined to involve a Wisconsin resident and policyholder who obtained treatment in CO and were removed from the sample. The written denial reflected the printed name of a "Support Clinician" who was either a Doctor of Chiropractic or a Physical Therapist; however, none of the adverse determination letters were signed by licensed physician.

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of § 10-16-113, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado as required by Colorado insurance law.

Issue K3: Failure, in some instances, to provide notification of determinations within the required timeframes. (*This was prior issue K1 in the findings of the 2002 final examination report.*)

Colorado Insurance Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review And Denial Of Benefits, promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

Section 6 Standard Utilization Review

A. Prospective review determinations.

1. Time period for determination and notification.

a. Subject to Subparagraph b. of Paragraph 1., a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request. Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.

C. Retrospective review determinations.

1. For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, *but in no event later than thirty (30) days after the date of receiving the benefit request.* [Emphasis added.] If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person in accordance with Subsection E.

UHC RETROSPECTIVE DENIAL DETERMINATIONS

Population	Sample	Number of Issues	Percentage of sample
25	25	3	13%

The examiners reviewed the entire population of twenty-five (25) UHC Retrospective Denied UR determinations. It appears that the Company is not in compliance with Colorado insurance law in that in three (3) instances, the Company failed to provide notifications within the required timeframes.

UHC RETROSPECTIVE APPROVED DETERMINATIONS

Population	Sample	Number of Issues	Percentage of sample
32	32	1	3%

The examiners reviewed the entire population of thirty-two (32) UHC Retrospective approved UR determinations. It appears that the Company is not in compliance with Colorado insurance law in that in one (1) instance, the Company failed to provide notification within the required timeframe.

UHC PROSPECTIVE DENIED DETERMINATIONS

Population	Sample	Number of Issues	Percentage of sample
6	6	1	16%

The examiners reviewed the entire population of six (6) UHC prospective denied UR determinations. It appears that the Company is not in compliance with Colorado insurance law in that in one (1) instance, the Company failed to provide notification within the required timeframe.

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Colorado Insurance Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division that it has implemented procedures to ensure that all utilization review determinations are made within the time periods required by Colorado insurance law.

In the Market Conduct examination for the period January 1, 2002 through December 31, 2002, the Company was cited for failure to make utilization review determinations and provide required notifications within the timeframes allowed under Colorado insurance law. The violation resulted in Recommendation #29; that the Company revise its procedures to ensure that the timeframes for determination and notification of utilization review decisions meet the requirements of Colorado insurance law. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Examination Report Submission

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